

AN INVESTIGATION OF THE EFFICACY
OF PLAY THERAPY WITH YOUNG CHILDREN
Marielle Aloyse Brandt, B.S.B.A, M.A.

Dissertation Prepared for the Degree of
DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

May 1999

APPROVED:

Sue C. Bratton, Major Professor
Michael K. Altekruze, Major Professor
and Chair of the Department of
Counseling, Development, and Higher
Education

David Baker, Minor Professor

Janice Holden, Coordinator of the
Program in Counselor Education

M. Jean Keller, Dean of the College of
Education

C. Neal Tate, Dean of the Robert B.
Toulouse School of Graduate Studies

Brandt, Marielle Aloyse, An Investigation of the Efficacy of Play Therapy with Young Children. Doctor of Philosophy (Counseling and Student Services), May 1999, 95 pp., 24 tables, references, 62 titles.

This study was designed to determine the effectiveness of play therapy as a method of intervention for children with a variety of emotional and behavioral problems. Specifically, the study was aimed at determining the effectiveness of play therapy in: (a) improving self-concepts of children with adjustment difficulties; (b) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety, and depression; (c) reducing externalizing behavioral problems such as aggression and delinquent behaviors; (d) reducing overall behavior problems, social problems, thought problems, and attention problems of children with adjustment difficulties; and (e) reducing parenting stress of parents of children who were experiencing adjustment difficulties.

The experimental group consisted of 15 children who were experiencing a variety of adjustment difficulties and received play therapy once per week for 7 to 10 weeks. The control group consisted of 14 children who were

experiencing a variety of adjustment difficulties and who were on a waiting list to receive intervention, and therefore, did not receive any treatment during the time of data collection. Experimental and control group children were administered the Joseph Pre-School and Primary Self-Concept Screening Test and parents of all participants completed the Child Behavior Checklist and the Parenting Stress Index at pretest and posttest data collection times.

A gain scores analysis revealed that children in the experimental group demonstrated a significant improvement on internalizing behavior problems. Also, a reduction in externalizing behavior problems and parenting stress was observed. No improvement in self-concept was demonstrated.

This study provides evidence that play therapy is a viable intervention for treating a variety of emotional and behavioral difficulties in young children, particularly children who are experiencing internalizing behavior problems.

Copyright 1999

by

Marielle Aloyse Brandt

TABLE OF CONTENTS

	Page
LIST OF TABLES	iv
Chapter	
I. INTRODUCTION	1
Statement of the Problem	9
Synthesis of Related Literature	10
History and Development of Play Therapy . . .	10
Rationale for Using Play Therapy	17
Clinical Efficacy of Play Therapy	20
II. METHODS AND PROCEDURES	29
Hypotheses	30
Definition of Terms	31
Selection of Participants	36
Limitations	40
Instrumentation	41
JPPSST	41
CBCL	43
PSI	44
Collection of Data	46
Statistical Analyses	48
III. RESULTS AND DISCUSSION	49
Results	49
Discussion	67
Recommendations	79
Concluding Remarks	80
APPENDICES	
A. Information for Parents	82
B. Parent Informed Consent	84
C. Child Informed Consent	86
REFERENCES	88

LIST OF TABLES

Table	Page
1. Gender and Mean Age of Participants by Group . . . .	.38
2. Multivariate Analysis of Variance for Change Scores on the Joseph Pre-School and Primary Self- Concept Screening Test (JPPSST), the Total Score on the Child Behavior Checklist (CBCL) and the Total Score on the Parenting Stress Index (PSI). . . . .	.50
3. Multivariate Analysis of Variance for Change Scores on the Internalizing Behaviors Subtest of the CBCL, the Externalizing Behaviors Subtest of the CBCL, the Parent Domain of the PSI, and the Child Domain of the PSI . . . . .	.52
4. Mean Scores and Standard Deviations on the JPPSST . .	53
5. Mean of Gain Scores on the JPPSST . . . . .	.54
6. Analysis of Variance Data for Mean Scores on the JPPSST . . . . .	.54
7. Mean Scores and Standard Deviations on the CBCL . .	.55
8. Mean of Gain Scores on the CBCL . . . . .	.56
9. Analysis of Variance Data for Mean Scores on the CBCL . . . . .	.56
10. Mean Scores on the Total Stress Scale of the PSI . .	.57
11. Mean of Gain Scores on the Total Stress Scale of the PSI . . . . .	.58
12. Analysis of Variance Data for Mean Scores on the PSI . . . . .	.58

Table	Page
13. Mean Scores on the Externalizing Behavior Problems Subscale of the CBCL . . . . .	.59
14. Mean of Gain Scores on the Externalizing Behavior Problems Subscale of the CBCL . . . . .	.60
15. Analysis of Variance Data for Mean Scores on the Externalizing Behaviors Subscale of the CBCL . . . . .	.60
16. Mean Scores on the Internalizing Behavior Problems Subscale of the CBCL . . . . .	.61
17. Mean of Gain Scores on the Internalizing Behavior Problems Subscale of the CBCL . . . . .	.62
18. Analysis of Variance Data for Mean Scores on the Internalizing Behavior Problems Subscale of the CBCL . . . . .	.62
19. Mean Scores on the Parent Domain of the PSI . . . . .	.63
20. Mean of Gain Scores on the Parent Domain of the PSI . . . . .	.64
21. Analysis of Variance Data for the Mean Scores on the Parent Domain of the PSI . . . . .	.64
22. Mean Scores on the Child Domain of the PSI . . . . .	.65
23. Mean of Gain Scores on the Child Domain of the PSI . . . . .	.66
24. Analysis of Variance Data for the Mean Scores on the Child Domain of the PSI . . . . .	.66

CHAPTER I

INTRODUCTION

Meeting the mental health needs of children is increasingly challenging due to limitations of the managed health care delivery system, coupled with alarming rises in child abuse and neglect, child violence, and emotional and behavioral problems of children (Friedman, 1997; Ginsberg, 1995; Gullotta, Adams, & Montemayor, 1998). Friedman (1997) argued that mental health services have been significantly affected by the increased reliance on managed care companies due to out-of-control costs of health care. Thus, issues of accountability, efficiency, and effectiveness play a larger role in mental health services than ever before. Furthermore, national statistics on children point to the need for greater efforts to provide services that will ensure the mental and emotional health of our children (Ginsberg, 1995). Ginsberg (1995) asserted, "the plight of children, perhaps the most disadvantaged Americans, will become increasingly severe as the development of services continues to lag behind the development of social problems

and needs" (p. 89). Importantly, unresolved childhood problems are likely to extend into adulthood, where their amelioration poses a much greater challenge. In order to effectively help young children who are experiencing emotional and behavioral difficulties, mental health professionals must be particularly sensitive to children's unique developmental needs (Landreth, 1991).

In the early years of development, children are rapidly undergoing cognitive, socio-emotional, and physiological changes. An important part of early development is the acquisition of language (Piaget, 1980). Piaget maintained that language development is structured by, and dependent upon, cognitive development. According to Piaget (1952), the child between the ages of 4 and 7 is in a preoperational stage of cognitive development and the child from 7 to 11 is in a concrete operational stage. Children at these stages have not yet developed the language capacity of adults. They have a limited ability to accurately articulate their life experiences and the content of their inner cognitive and emotional world (Landreth, 1991). Rather than continuously engage in verbalizations to express their inner life, as do adults, children in the preoperational and concrete operational

stages are absorbed in play throughout most of the waking day, acting out their experiences, experimenting with adult roles, rehearsing for future events, developing competencies, achieving mastery, and simply trying to make sense of their world (Landreth, 1991).

The preoperational stage is characterized by the development of basic language and other forms of representation and rapid conceptual development (Wadsworth, 1984). According to Piaget, preoperational thought is prelogical. Children at this stage are not able to perform operations, or, schemas of connected relational reasoning. For example, preoperational children cannot conserve, or grasp the reality that two things that are equal remain so if their shape is manipulated. Also, their logic is also limited by irreversibility: once they concentrate on one aspect of a phenomenon, they have difficulty reverting to a previously experienced perception of that same event or object. Next, children at this stage reason by transduction: they move from particular to particular without taking the general into account, and simultaneous events seem to have a cause and effect relationship. Finally, they tend to centrate, focusing on one aspect of a situation and neglecting others, and cannot decenter, or

think about several aspects of an event simultaneously.

Through the developmental processes of assimilation and accommodation, the plethora of experiences and activities that fill children's lives during their early years lead them into the stage of concrete operations at about age 7 (Wadsworth, 1984). Children at this stage are able to think logically about the here and now, conserve quantities, serialize items, and deal with logical relationships. They also begin to assimilate the concepts of time and space. However, problem solving remains at the trial and error level. Children generally remain in this stage until about age 11.

Piaget has probably been one of the most influential child developmentalists, fostering increased sensitivity toward and awareness of the uniqueness of children's capacities at varying stages of cognitive development. Piaget's (1962) research has indicated that children are not able to competently engage in abstract reasoning until about the age of 11, which supports the notion that children have an underdeveloped capacity for language processing. Despite his landmark contributions to the body of knowledge on children's cognitive development and language acquisition, researchers following Piaget's work

have suggested that even Piaget had a tendency to overestimate the young child's cognitive ability to understand and use language. In several experiments, children misinterpreted tasks they were asked to perform and had difficulty retelling stories they had just heard (Mandler, in Pines, 1983). Often, children had an accurate grasp of cause and effect relationships, but experienced difficulty comprehending language and using language to convey their understanding of events. This research further supports the notion that children have an underdeveloped capacity for language.

Language is a complex process that requires the ability to abstract (Piaget, 1980). Since words are made of abstract symbols, language requires the ability to form abstract cognitions and to effectively verbalize those cognitions in order to be utilized proficiently. Before the age of 11, children are developmentally functioning in a concrete reality where their capacity to verbalize their knowledge of experiences is far less than that of adults. Language is only one way among others to communicate one's knowledge (Sinclair-deZwart, 1973). Unlike adults, whose natural medium of expression is verbalization, the child's natural medium of self expression is play (Axline, 1947;

Ginott, 1960; Landreth, 1991).

Child psychotherapy that relies solely on verbal interaction between child and therapist does not appropriately address the developmental needs of young children, who communicate their thoughts and feelings most effectively by playing them out. Landreth (1993) contended, "Play is the most complete form of self-expression developed by the human organism" (p. 42). "Play is the singular central activity of childhood, occurring at all times and in all places" (p. 41), and in all cultures. Play has structure and form, content and symbolism, and it mirrors the developmental shifts of each child's socio-emotional and cognitive world. Play does not depend on external rewards or other people's direction, has no goal or purpose, and does not occur in novel or frightening situations (Lowenfield, 1991; O'Connor, 1991; Landreth, 1982; McMahon, 1992; & Krall, 1989).

For children, play is the natural, spontaneous, and comfortable medium through which children express themselves (Axline, 1947). Play facilitates the child's development of expressive language, communication skills, emotional development, social skills, decision-making skills, and cognitive development. Play fosters exploration

and discovery of interpersonal relationships, understanding of personal thoughts and feelings, development of sexual identity, and experimentation with adult roles (Landreth, 1993).

In order to effectively meet the mental health needs of children, therapists must leave the abstract world of verbalization and enter the child's world of concrete reality via the child's language, play. Landreth (1991) believed, "A therapeutic working relationship with children is best established through play, and the relationship is crucial to the activity we refer to as therapy. Play provides a means through which conflicts can be resolved and feelings can be communicated" (p. 11). Play in and of itself will not always produce significant emotional and behavioral changes. A critical component of any child therapy that incorporates play is the therapist's interventions and utilizations of the play (Gil, 1991).

Play therapy is a developmentally-sensitive approach to helping children with their problems. Play therapy "is a well thought-out, philosophically conceived, developmentally-based, and research-supported method of helping children cope with and overcome the problems they experience in the process of living their lives" (Landreth,

1996, xiii). Play therapy allows children to work through their problems at their own pace via the natural expression of play with a trained play therapist who facilitates an atmosphere where children can safely express feelings, thoughts, and behaviors within acceptable limits.

Children are referred for play therapy with a number of conditions identified by the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (1994), as well as other behavioral and emotional difficulties not specifically described by the manual (Landreth, et al., 1996). Such conditions include but are not limited to problems with self-concept, behavioral and emotional problems, learning difficulties, and problems in parent-child relationships. An abundance of descriptive and theoretical works has shown improvement in these areas when children have received play therapy. Studies have suggested that play therapy can be effective in helping abused and neglected children, decreasing aggression, improving the emotional adjustment of children from divorced families, reducing stress and anxiety in hospitalized children, ameliorating symptoms of autism, helping blind children adjust, reducing fear and anxiety, helping grieving children, and helping with a variety of other adjustment problems (Landreth, Homeyer,

Glover, and Sweeney, 1996).

Unfortunately, there are few well-defined and well-executed research examples of play therapy's effectiveness. This presents a problem for practitioners in the field of play therapy: there appears to be little empirically validated evidence to support their cause. Case studies supporting the clinical efficacy of play therapy are not enough to ward off critics who question whether or not play therapy can even be considered therapy. Moreover, in this day of accountability demanded by the legal system and managed care providers, play therapists must increasingly be able to document the effectiveness of play therapy procedures (Landreth, et al., 1996). Empirically validated research is needed for those who are required to justify their recommendations for play therapy services. Despite the wide use of play therapy and the number of play therapy studies in the literature, there are few studies that experimentally measured the effectiveness of individual play therapy. Additionally, the studies produced have utilized a specific client population, such as abused children, anxious children, and developmentally delayed children, therefore, lacking generalizability.

Statement of the Problem

The problem to be investigated was the efficacy of play therapy as an intervention for children experiencing a variety of adjustment difficulties. Specifically, the following were used as determining factors: children's self-concepts, internalizing and externalizing behavioral problems, and stress in the parent-child relationship.

Synthesis of Related Literature

The review of the literature concentrates on the following three elements: (a) History and Development of Play Therapy, (b) Rationale for Using Play Therapy, and (c) Clinical Efficacy of Play Therapy.

History and Development of Play Therapy

Prior to this century, cognitive and emotional difficulties of children were not recognized. Instead, children's negative behavioral manifestations were attributed to forms of excess such as studying or working too hard, climatic changes, or being frightened or shocked (Gelfand, Jensen, & Drew, 1997). Little was understood about human development and stages of development, and thus, it was commonplace for children to be viewed as miniature adults. By the turn of the century, no methods or approaches to working with children could be considered

child psychotherapy (Kanner, 1957, as cited in Landreth, 1991). In the early part of this century, however, children's problems started gaining recognition and there were several attempts to administer psychological treatment to children.

Sigmund Freud authored the first published case describing a psychological approach to working with a child in 1909. This was the classic case of "Little Hans," a five year old boy with a phobia. Importantly, "Little Hans" is the first recorded case in which a child's problems were attributed to emotional difficulties (Landreth, 1991). Freud treated Hans indirectly by advising the child's father of ways to resolve Hans' underlying conflicts and fears. Freud's work led others to investigate the utilization of psychotherapy with children.

There are four major developments in play therapy: psychoanalytic play therapy, release therapy, relationship therapy, and non-directive therapy. The first major development in play therapy took place after efforts to apply psychoanalysis to children proved to be ineffective and inappropriate. Analysts discovered that unlike adults, children did not verbalize their anxieties. Furthermore, children were reluctant to describe issues in their past

and resisted attempts to have them free-associate (Landreth, 1991).

Play was not directly used in child therapy until 1919 by Hermine Hug-Hellmuth (O'Connor, 1991). Hug-Hellmuth was one of the first therapists to emphasize the importance of child therapy and to provide play materials to children in therapy to foster self-expression. Although she did not develop a theoretical approach, she did discourage the application of methods of adult analysis to children (Landreth, 1991).

Shortly after Hug-Hellmuth introduced the use of play in child therapy, Melanie Klein (1955) began utilizing play to analyze children under the age of six years. Klein believed that play therapy provided direct access to the child's unconscious. Therefore, analysis took place without needing the child to "free associate." In essence, the child's play served as a substitute for verbalization and free association, and provided the material (e. g. the expression of the unconscious) from which she drew her interpretations. Klein also believed a key role of the therapist was to be a facilitator of transference. According to Klein, the best way to explore the child's unconscious was to analyze the child's transference

relationship with the therapist (Landreth, 1991).

In 1928, Anna Freud (1946) applied principles of psychoanalysis to children in therapy. However, Freud did not agree with Klein's view in the necessity of the therapist being a facilitator of transference or with Klein's use of interpretations which she felt to be excessive and extreme (Schaefer, 1985). Instead, she used play as a means of developing a therapeutic alliance - an emotional relationship - with the child before interpreting the unconscious motivations behind a child's behavior. Thus, play was utilized as a means of fostering the child's emotional attachment to the therapist in order to attain access to the child's inner world.

Although Klein and Freud used play in different ways, the primary goal of each of their approaches was to help children work through difficulties by facilitating insight. The two women both agreed that the therapist should work to uncover the child's past and to strengthen the child's ego by understanding and interpreting the symbolic content of the child's play.

The 1930's marked the second major development in play therapy with the introduction of release therapy. David Levy (1939) developed this structured approach for working

with children which is characterized by the following: (1) a psychoanalytic framework, (2) at least a partial belief in the cathartic value of play, and (3) the active role of the therapist in determining the course and focus of therapy (O'Connor, 1991). Levy (1939) differed from psychoanalysts in that he believed the release play therapist should not utilize interpretations or attempt cognitive restructuring. The child's play was not used as a means of achieving insight. Instead, he viewed the therapeutic experience as an opportunity for the child to abreact feelings associated with traumatic events.

Gove Hambidge (1955) expanded upon Levy's release therapy, retitling it "structured play therapy." He saw structured play therapy as a technique used whereby the therapist implements a series of stimulus situations that the child plays out. The therapist assumes the responsibility for the play therapy experience. The therapist's job is to gain background from the child's family and to attempt to recreate in dramatic play an event or situation like the one causing distress (Landreth, 1991). Hambidge attempted to directly recreate the event or anxiety-producing situation to facilitate the child's abreaction. "Structuring a child's play so he or she

reexperiences a stressful situation can not only allow for a release of pent-up emotions but also assist the child to cognitively assimilate the event and master it" (Schaefer, 1985, p. 101).

The third significant development in play therapy took place with the emergence of relationship play therapy. This approach is based on the work of Otto Rank (1936), who stressed the importance of birth trauma in development. Rank de-emphasized the significance of transference and past events in therapy. His focus was on the therapist-client relationship and the here and now of the client's life. Taft (1933), Allen (1934), and Moustakas (1959) applied Rank's basic philosophical principles to work with children in play therapy (as cited in O'Connor, 1991). All three believed that birth trauma may cause children to have difficulty individuating from their primary caretaker and to have problems forming deep positive relationships.

In relationship play therapy, emphasis is placed on the "curative power" (Landreth, 1991, p. 31) of the therapeutic relationship. Allen (1942) asserted, "Therapy emerges, then, from an experience in living, not in isolation but within a relationship with another from whom the patient can eventually differentiate himself as he

comes to perceive and accept his own self as separate and distinct" (p. 49). In this approach, the child takes the lead in the therapy process, and the therapist focuses on material that is of importance to the child.

The work of Virginia Axline (1947) marked the fourth major development in play therapy. Axline modified concepts of Carl Rogers' non-directive therapy and applied them to children in play therapy. The objectives of non-directive play therapy are self-awareness and self-direction (Landreth, 1991). In non-directive play therapy, the therapist does not attempt to foster a transference relationship, to offer interpretations, to structure the session, or to lead the child's play in any way. Instead, the non-directive play therapist "actively reflects the child's thoughts and feelings believing that when a child's feelings are expressed, identified, and accepted, the child can accept them and then is free to deal with these feelings" (Landreth, 1991, p. 32).

Axline (1947) argued that children have within them all of the necessary components for growing and becoming. She stressed the importance of the relationship between therapist and child, which allows the child to feel safe so that the process of growth may occur. Through the

therapeutic relationship, the child is able to achieve emotional maturity and to grow through expression and exploration of the various levels of the emotional process. Until the relationship conveys conditions of empathy, warmth, and permissive understanding in the playroom, the child will continue to be maladjusted. Once the child experiences a relationship where he/she feels fully accepted, respected, and understood, the child is free to fully experience self and is driven towards health and a self-directed life.

Recent developments in play therapy have concentrated on integrating elements of the aforementioned approaches into other theoretical frameworks and applications. For example, the development of Gestalt play therapy, Adlerian play therapy, family play therapy, and the introduction of filial therapy (training parents in child-centered techniques).

Rationale for Using Play Therapy

Children's problems are complicated by communication barriers with adults in their lives. Often, adults are unable to understand or to respond appropriately to children's feelings or attempts to communicate (Landreth, 1982). Adults express their thoughts and feelings through

verbalization, which is a formal mental process requiring the ability to transform personal experiences into abstract symbols. Children do not have the capacity to accurately perform such complex operations until the age of eleven (Piaget, 1962). Instead, children express their thoughts and feelings via play (Ginott, 1960). To limit young children to strictly verbal communication is to deprive them of the means by which they communicate.

Ginott (1960) posited that the rationale for using play in the diagnosis and treatment of maladjusted children is that play is the child's symbolic language of self-expression. "Through the manipulation of toys the child can state more adequately than in words how he feels about himself and the significant people and events in his life. To a considerable extent, the child's play is his talk and the toys are his words" (p. 243). Children develop character through experiences with persons and situations, which does not come about as a result of words. They internalize their experiences, assimilate them, and make them a part of their personality.

Lowenfield (1935) contended that the process of play therapy bridges the gap between the child's consciousness and emotional experiences. She reasoned that its

therapeutic usefulness is derived from the fact that it represents to children the externalized expression of their emotional lives and "fulfills the role that conversation, introspection, philosophy, and religion have for the adult" (p. 324). Likewise, Froebel (1912) argued, "Play....is the highest expression of human development in childhood, for it alone is the free expression of what is in a child's soul." (as cited in Lowenfield, 1935, p. 30).

Axline (1947) believed play allows children to express themselves in areas that have been pressing for expression and exploration. Through play, the child is able to feel and release feelings and attitudes that need to be resolved. By "playing out" emotions, the child is able to realize the power the child has to make decisions and to become an independent and mature person. Lowenfield (1935) asserted, "without adequate opportunity for play, normal and satisfactory emotional development is not possible (p. 324).

Erikson (1964) asserted, "I propose the theory that child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experience and planning"(p. 10). Furthermore, he summarized his rationale for utilizing play

as a therapeutic technique when he said, "The child uses play to make up for defeats, sufferings and frustrations, especially those resulting from a technically and culturally limited use of the language" (Erikson, 1940, p. 561).

Moustakas (1959) contended that play in and of itself is not therapeutic, but rather a relationship that develops in a free play situation based on faith, acceptance, and trust is therapeutic. Patterson (1974) concurred with this line of thinking when he posited that children can only grow and develop fully as persons in the context of relationships with other people. In the same vein, Landreth (1991) emphasized the importance of the therapeutic relationship in play therapy. Of particular importance is "the ability of the therapist to understand the child's communications and to create an environment which allows the child to communicate freely" (p. 117). The attitude and skill of the therapist creates the therapeutic environment while play provides the medium through which the child can communicate.

Clinical Efficacy of Play Therapy

Play therapy has been utilized and assessed for effectiveness in a number of studies and with a variety of

populations. However, little research has been experimentally designed. Most has been in the form of case studies or anecdotal reports. Case studies have been described as the weakest approach to assessing treatment outcomes due to the lack of internal and external validity (Gall, Borg, & Gall, 1996) and the inability to control for confounding variables. LeBlanc (1998) stated, "While case study or descriptive research provides an interesting perspective of play interventions and suggests its effectiveness, such research should not be considered as evidence of the utility of play therapy" (p. 39). Experimental studies are preferred to case studies since they increase the validity of research by controlling for the effects of extraneous variables. Experimentally designed studies involve at least two equivalent groups of children formed by randomization procedures: a treatment group and at least one comparison group. The following section includes controlled studies concerned with determining the effectiveness of play therapy; specifically, the available studies that investigated the effectiveness of individual play therapy.

Bills (1950) tested the use of child-centered play therapy to improve reading skills of third graders who were

experiencing delayed reading development. Statistically significant gains in reading skills were observed in the treatment group after receiving six individual and three group play therapy sessions. The results were believed to be from either: (1) the children having learned at a more rapid pace because of the play therapy or, more likely, (2) the children were able to maximize retained information that they had previously experienced difficulty using effectively.

Mundy (1957) assessed the impact of non-directive play therapy on levels of I.Q. and social adjustment of children who were mentally challenged. Quantitative results indicated relevant differences between treatment and control groups with respect to I.Q. measurements. A qualitative assessment of social adjustment determined that after treatment, most of the children in the treatment group became qualified for special academic programs for which they had previously been considered unqualified. Additionally, there were observed decreases in tantrums, while socially cooperative and constructive behaviors increased.

Siegel (1970) investigated the efficacy of child-centered play therapy in a year-long study. Forty-eight

second to fifth grade children with learning disabilities were divided into the following groups: children who received play therapy, children whose parents received parental counseling, children who received play therapy and whose parents received parental counseling, and children assigned to a control group. Learning disabled children who received play therapy demonstrated significant improvement in cognitive, affective, psychomotor, and environmental domains.

Pelham (1972) found play therapy to be an effective intervention for immature kindergarten children. Pelham sought to determine whether self-directed play therapy effectively increases the social maturity of kindergartners who had been identified by teachers as socially immature. When compared children in the control group, children who had received either individual or group play therapy demonstrated significantly increased maturity. Measures of self-concept and flexibility to new experiences revealed that children in these two groups scored more positively than those in the control group. In addition, classroom behaviors as reported by teachers improved significantly.

Newcomer and Morrison (1974) assessed the impact of play therapy interventions on the social and intellectual

functioning of institutionalized children who were mentally challenged. Quantitative analysis revealed significant results both for children receiving individual play therapy and children receiving group play therapy. Children in the control group demonstrated no change. Additionally, the results revealed no difference in the efficacy of individual versus group play therapy. Qualitative observations corresponded with the quantitative results and suggested that directive play therapy may be more effective in treating children's emotional and behavior problems than non-directive play therapy.

Oulline (1975) studied the effects of short-term child-centered play therapy with preschool children who were deaf and exhibited behavioral difficulty. Statistical analysis revealed a significant increase in mature behavioral patterns for children who received the play therapy. In addition, data from questionnaires revealed that all the parents and teachers of seven of the children in the treatment group reported positive behavioral changes after completion of the 10-weeks.

Clatworthy (1981) investigated the effectiveness of play therapy in treating children who experienced hospital-induced anxiety. Children in the experimental groups

displayed significantly lower levels of anxiety than did control group subjects. Statistical analysis indicated that the treatment did not reduce the anxiety of children in the experimental group, but rather, it prevented them from developing as much anxiety as did the children in the control group.

Milos and Reiss (1982) measured the differential effects of directive and non-directive play therapy in reducing separation anxiety in young children. Subjects were assigned to four groups: free play, directed play, modeling, and a control group. Results revealed a significant reduction in anxiety in the treatment groups as compared to the control group. There were insignificant differences between the results of the three treatments groups. The results were reported to be related to factors pertaining to the play itself and the presence of a nonjudgmental adult. Furthermore, the authors concluded that the child's level of emotional involvement in play and not the setting in which play occurs is what influences the quality of play.

Perez (1987) examined the differential effects of using individual and group play therapy in the treatment of sexually abused children. Specifically, the study measured

the change of self-concept and self-mastery over the course of treatment. Statistical analysis revealed significant results for both treatment groups as compared to the control group, and indicated that play therapy benefited children regardless of age, gender, type of abuse, or current living arrangements. There were no significant differences in treatment effects between individual and group play therapy.

Daniel, Rae, Sanner, Upchurch, & Worschel (1989) studied the effects of play on the psychosocial adjustment of children hospitalized for acute illness. Specifically, they examined the effects of play therapy on the children's "hospital fears." The statistical results indicated children who received child-centered play therapy displayed a significantly lower level of fear than children in two other treatment conditions and children in the control group. There were no significant differences in the results between the comparison groups and the control group.

Crow (1990) measured the effects of play therapy on the self-esteem of poor readers. Children who received play therapy experienced statistically significant increases in self-concept, increases in internal locus of control, and gains in their reading ability. The control group

experienced equal gains in reading ability but displayed no improvement in their internal locus of control.

Quayle (1991) explored the effectiveness of play therapy with early elementary school children having problems adjusting to school. Children in the treatment group received individual play therapy and those in the comparison group received group play therapy. Both groups demonstrated improvement after treatment, while the control group experienced negative results in 7 of 11 areas. Children who received play therapy improved in learning skills, assertive social skills, task orientation, peer and social skills, interactive participation, and self-confidence.

Kot (1995) investigated the effectiveness of intensive child-centered play therapy on child witnesses of domestic violence. Kot sought to determine the effect of play therapy on improving self-concepts, internalizing and externalizing behaviors, problem behaviors, and playroom behaviors. The results indicated that after receiving play therapy, children in the experimental group demonstrated the following: (1) significant improvement in self-concept, (2) significant reduction in overall behavioral problems, and (3) significant improvement in the play behaviors of

physical proximity and play themes. No improvement was noted in the following: internalizing behavior problems and the play behaviors of affection, contact, self-direction, aggression, mood, and food nurturing themes.

Experimental studies such as those discussed in this section provide more valid and widely accepted results than do case studies. By implementing controlled studies, researchers can be more confident that their results are due to the effects of play therapy and therapists can gain the empirical validation needed to support their cause: to provide the necessary and appropriate mental health care for children within the parameters of the managed health care delivery system.

CHAPTER II

METHODS AND PROCEDURES

A quasi-experimental design was utilized in this study to measure the effectiveness of individual play therapy with young children experiencing a variety of behavioral and emotional problems. Participants were children ages 4 through 6 with a variety of adjustment difficulties (n=29). Both experimental group (n=15) and control group (n=14) participants were referred by parents and/or teachers for counseling due to adjustment difficulties. Only the experimental group received play therapy. At termination of the study and as counselors became available, control group participants received intervention for their presenting adjustment problems. No child was denied treatment as a result of being in the control group.

Self-concept of the child participants was measured by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST). A global score indicates the child's self-concept. Child participants' behaviors were rated by one of the child's parents via completion of the Child Behavior

Checklist (CBCL). The specific behaviors measured are grouped under Internalizing Behavior Problems and Externalizing Behavior Problems. The total score also includes social problems, thought problems, and attention problems. Parent participants' stress levels were rated by their completion of the Parenting Stress Index (PSI). Specific levels measured are categorized in a Child Domain and a Parent Domain.

The following discussion includes the hypotheses, definitions of terms, instrumentation, selection of subjects, collection of data, and the statistical analyses.

Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

- 1) Children in the experimental group will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) at posttesting than will children in the control group.
- 2) Children in the experimental group will attain a significantly lower mean total score on the Child Behavior Checklist (CBCL) posttest than will children in the control group.
- 3) Parents of children in the experimental group will

attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will children in the control group.

- 4) Children in the experimental group will attain a significantly lower mean score on Externalizing Behavior Problems on the CBCL posttest than will children in the control group.
- 5) Children in the experimental group will attain a significantly lower mean score on Internalizing Behavior Problems on the CBCL posttest than will children in the control group.
- 6) Parents of children in the experimental group will attain a significantly lower mean total score on the Parent Domain of the PSI posttest than will children in the control group.
- 7) Parents of children in the experimental group will attain a significantly lower mean total score on the Child Domain of the PSI posttest than will children in the control group.

Definitions of Terms

Adjustment Difficulties

Problems that prevent children from adjusting to life

experiences, family experiences, school situations and learning opportunities are considered adjustment difficulties. Such difficulties may include the following: hyperactivity, impulsivity, inattentiveness, anxiety, extreme shyness, withdrawn behavior, and depression. Precipitating factors may be a tumultuous family environment, or abrupt life changes such as divorce, changing residence, or death in the family.

Externalizing Behaviors

Externalizing behaviors are emotional difficulties that are expressed as outward delinquent and aggressive behaviors from the child to another person or object in his/her environment. For this study, externalizing behaviors will be operationally defined as the score on the Externalizing Behavior subscale of the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Internalizing Behaviors

Internalizing behaviors are those manifestations of emotional difficulty that are directed inwardly, resulting in symptoms such as anxiety, depression, withdrawal, and somatic complaints. For the purpose of this study, internalizing behavior problems will be operationally defined as the score on the Internalizing Behavior subscale

of the Child Behavior Checklist (Achenbach, 1991).

Parental Stress

Parental stress refers to the degree of stress evidenced in the parent-child relationship, as perceived by the parent. For the purpose of this study, parental stress will be operationally defined as the scores on the Parenting Stress Index (PSI) (Abidin, 1993).

Play

Play is the child's means of assimilating experience and making sense of the world, linking reality to the child's inner psychological and emotional life. In this investigation, play is defined as:

all activities of children that are spontaneous, self directed, and intrinsically motivated wherein a child experiments with fantasy and reality, expresses feelings and thoughts, explores relationships, acts out experiences, rehearses for future events, deals with success and failure, assimilates and integrates new information, and experiences self-fulfillment

(Lowenfield, 1991; O'Connor, 1991; Landreth, 1982; McMahon, 1992; & Krall, 1989).

Play Therapy

Landreth (1991) defined play therapy as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (thoughts, feelings, experiences, and behaviors) through the child's natural medium of communication, play (p. 14).

Play Therapists

The play therapists employed in this study were 13 graduate students (11 masters and 2 doctoral) majoring in counseling at the University of North Texas who had received special training in play therapy. All therapists utilized in the study were theoretically grounded in humanistic approaches to counseling. Therefore, their interventions were not "problem-solving" in nature, but rather, they sought to provide a therapeutic climate that would help to release the child's innate potential to improve his or her own situation. All masters students were enrolled in an on-site practicum course, the final phase of their counseling training, where they were closely supervised by a faculty member and at least one doctoral teaching assistant as they counseled clients from the

community. One of the doctoral students was enrolled in an advanced practicum course (taken the first year of doctoral study) and the other was fulfilling internship requirements (performed the second year of doctoral study). Both doctoral students were supervised by faculty members who are licensed professional counselors and registered play therapists. At a minimum, all of the participating play therapists had successfully completed an introductory course in play therapy, which included both didactic and experiential training. The course utilized a seminar-type approach to instruction, whereby students were taught play therapy principles and were given the opportunity to apply knowledge and practice skills during class time. Additionally, students taking this course were required to participate in a mini-practicum, where they facilitated play sessions with children in an intensively supervised setting. Supervision was provided by doctoral students who were experienced play therapists and had received advanced training in play therapy.

Self-Concept

Self-concept refers to the extent to which one values one's worth and is comprised of the attitudes, thoughts, and feelings one holds about oneself. A healthy self-

concept may include characteristics such as feelings of competence and mastery, confidence, security, and contentment (or freedom from tension); and be demonstrated by flexibility, spontaneity, independence, sociability, individuality, trustfulness; with a realistic appraisal of self, relationships, and environment (Brownfain, 1965; Rogers, 1951). In this study, self-concept will be operationally defined as the children's total scores on the Joseph Pre-School and Primary Self-Concept Screening Test (Joseph, 1979).

Selection of Participants

For the purpose of this investigation, participants were young children referred by parents and teachers for counseling due to adjustment difficulties. Experimental participants were randomly selected from two counseling clinics housed at the University of North Texas: the Child and Family Resource Clinic (CFRC) and the Counseling and Human Development Center (CHDC). Both clinics provide services to community clients for individual, marriage and family, and play therapy for the purpose of training masters and doctoral counseling students. All children from these clinics who met the criteria for this investigation were utilized. Control group participants were selected

from an elementary school in the Denton County Independent School District. Specifically, the group consisted of children who were randomly selected from a group of children identified by parents and/or teachers as having adjustment difficulties.

The elementary school children were utilized as a control group for several reasons. First, there was difficulty establishing an equivalent control group (i.e. a waiting list control group at CFRC or CHDC) without denying participants treatment for at least some period of time. Next, the elementary school population supplied a large number of children referred for adjustment problems with an insufficient number of counseling personnel to provide treatment for the children. This created a naturally-occurring waiting list from which to draw control group participants.

A total of 29 children were selected for the study: a control group of 14 participants and an experimental group of 15 participants. All participants were utilized in the study. However, not all of the instruments were successfully administered to every participant. For example, one child refused to complete the JPPSST at both pretest and posttest administration times. Also, another

child's parent did not complete the posttest CBCL. Still, another child's parents participated in neither the pretest nor posttest administration of the PSI. Therefore, for each statistical analysis implemented in the study, there were exactly 13 participants utilized from each group (experimental group, n=13; control group n=13) for a total of 26 participants. Table 1 includes the distribution of the experimental and control groups along the dimensions of gender, number and mean ages for each group.

Table 1.

Gender and Mean Age of Participants by Group

Group	Number of Boys	Number of Girls	Total Number	Mean Age
Experimental	5	10	15	5.38
Control	6	8	14	5.72
Total Participants	11	18	29	5.54

Despite the fact that the control group was not drawn

from the same population as the experimental group, the similarities of presenting problems of children in the two groups was striking. Participants in the experimental group consisted of children ages 4.42 to 6.5 years with a mean age of who were referred for counseling by parents or guardians for a variety of adjustment difficulties such as low self-esteem, anxiety, aggressiveness, depression, inattention, impulsivity; or behaviors related to difficulty adjusting to life events such as parental divorce, parent relationship problems, parent-child relationship problems, family violence, sexual abuse, or a death in the family. Participants in the control group were children ages 5.33 to 6.25 (mean age = 5.72) who were referred for counseling by parents and/or teachers due to difficulties such as shyness, withdrawal, anxiety, aggressiveness, depressive or inattentive behavior; or behaviors related to difficulty adapting to life changes such as parental divorce, moving, or adjusting to a new sibling.

All subjects were selected to participate in the study based on the following criteria: a) must be a child of age 4 to 6 who is not currently receiving therapy; b) must be able to participate in 7-10 play therapy sessions; c)

parents or guardians of child must be able to speak, read, and understand the English language; d) child must be able to speak and understand the English language; e) parents or guardians of child must be willing to complete pretest and posttest instruments and sign a consent to participate form; f) child must be willing and able to complete pretest and posttest instruments; g) no child was excluded on the basis of sex, ethnicity, or religion.

Limitations

This study had the following limitations:

1. The number of participants in both the experimental and control groups was small.
2. The study did not control for history or maturation due to the nature of the design.
3. The treatment took place over a short period of time. Therefore, the potential effects of play therapy may not have been realized.
4. No follow-up instrument was administered to investigate the long-term effects of receiving play therapy.
5. Control group participants came from a similar but distinct population.
6. The age ranges between experimental and control

group participants were unequivalent.

7. Therapists were beginning play therapists with a limited amount of experience.

Instrumentation

In order to determine the effectiveness of play therapy, changes observed in children who had received play therapy were measured. In this study, three instruments were administered: the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST), the Child Behavior Checklist (CBCL), and the Parenting Stress Index (PSI).

Joseph Pre-School and Primary Self-Concept Screening Test

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) was developed by Joseph (1979) to measure the self-concept of children. Although it was originally developed for preschool children, it was later adapted to include children in upper grade levels. The JPPSST can be used for children in the age range from three years six months to nine years, eleven months. This instrument has many benefits such as not requiring verbal or reading skills, requiring minimal training for the questioner, and being relatively short.

In administering the JPPSST, pictures are used to stimulate responses from children. First, the child

identifies the pictures as pictures of himself or herself. By using the child's descriptions of the activities and feelings surrounding the pictures of the child, the administrator rates the child's self-esteem on a global index scale ranging from 0 to 30.

The reliability of the JPPSST was established with a test-retest sample which produced a reliability coefficient of .87. Internal consistency was established through a split-half test. The Kuder-Richardson 20 formula was used to estimate the internal consistency which is in a range from .59 to .81 with a medium correlation of .73. An item analysis was also performed with item discrimination coefficients ranging from .30 to .70 as a function of the particular item and the age level of the sample. Every item on the scale obtained correlation coefficients indicating that each item significantly contributes to the overall test score performance.

Construct validity was addressed by correlating global self-concept scores derived from two self-concept rating scales that were completed by teachers. The correlation coefficient between the scores of the two tests equaled .51 which was significant at the .01 level of significance (Joseph, 1979).

The Child Behavior Checklist (CBCL)

The Child Behavior Checklist (CBCL) is one of the most extensively used research behavior checklists in child psychopathology. This instrument is used to assess parents' perceptions of their child's behaviors and competencies. The instrument consists of 113 Likert-type items that assess internalizing and externalizing behaviors across the following eight domains: Anxious/Depressed, Social Problems, Thought Problems, Somatic Complaints, Withdrawn, Attention Problems, Aggressiveness, and Delinquency (Achenbach, 1991).

The CBCL has been tested extensively for reliability (Achenbach & Edelbrock, 1983). Internal consistency is built into the measure, as the syndrome scales were derived from principal component analyses of the correlations among items. Cronbach's alpha is .90 for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems for girls ages 4 to 11. For boys ages 4 to 11, Cronbach's alpha is .89 for Internalizing and .93 for Externalizing Behavior Problems. Cronbach's alpha represents the mean of all possible sets of half the items comprising a scale.

Test-retest reliability of the CBCL was established at .89 for Internalizing Behavior Problems and at .93 for

Externalizing Behavior Problems, with the establishment of long-term stability at .70 for Internalizing Behaviors and .86 for Externalizing Behaviors. Children who received psychological intervention obtained long-term stability coefficients that were generally lower with significant reduction in problem scores, therefore indicating the CBCL is responsive to the effects of interventions with children.

The construct validity of the CBCL was supported by several studies (Kelley, 1985). Additionally, content validity was supported by the ability of nearly all CBCL's scale scores to discriminate between demographically matched referred and non-referred children. Criterion-related validity was also established. Using the 90 percentile of the behavior problem scores, the misclassification rate on the behavior problem scale was only 9.8 percent on predicting referred from non-referred children (Achenbach & Edelbrock, 1983). Furthermore, demographic variables accounted for only a small portion of score variances (Kelley, 1985).

Parenting Stress Index (PSI)

The Parenting Stress Index (PSI) is a popular and widely accepted research measure of parenting stress.

Specifically, the instrument is designed to measure levels of stress in the parent-child relationship as perceived by the parent (Abidin, 1983). The 101 items are divided into two primary domains: the Parent Domain and the Child Domain. The Parent Domain is comprised of 54 questions, addressing parent characteristics that pertain to the following subcategories: Depression, Attachment, Restriction of Role, Sense of Competence, Social Isolation, Relationship with Spouse, and Parent Health. The Child Domain contains 47 questions assessing parents' perceptions of their child in areas of Adaptability, Acceptability, Demandingness, Mood, Distractibility/Hyperactivity, and Parent Reinforcement. The PSI is a Likert-type scale, and scores are illustrated in raw score and percentile ranks for each subscale, the Parent Domain Total, the Child Domain Total, and the overall Total Score. Higher scores in any of these categories indicate higher levels of stress and perceived negative behavior.

Several studies have been conducted to determine the reliability of the PSI. A test-retest method was conducted to determine a coefficient of reliability (Zakreski, 1983). The study found coefficients of .78 for the Child Domain, .69 for the Parent Domain, and .88 for the Total Stress

Score. In addition, alpha reliability coefficients of .89, .93, and .95 were reported for the Total Stress Score, the Parent Domain, and the Child Domain respectively (Hauenstein, Scarr, & Abidin, 1986). Crowley (1995) tested the internal consistency of the instrument and found it to be .91, with a three-year test-retest reliability to be .73. These findings all support the reliability of the PSI.

Collection of Data

The investigator met with qualified participants and their guardians prior to the beginning of the investigation to: a) explain the purpose and requirements of the study; b) provide information pertaining to the maintenance of confidentiality; c) address any questions or concerns of participants and their guardians; and d) obtain informed consent. The guardian was asked to identify the child by writing the child's name on the consent form prior to signing it. In addition, the child was given a copy of the child consent form to read or look at as the investigator read the form aloud to the child. The child was asked to sign or make his or her mark if the child agreed to participate.

After obtaining informed consent from parents, each subject in the experimental group participated in a 45-

minute play therapy session once per week for 7 to 10-weeks. The individuals administering the treatment, play therapy, were graduate students who were pursuing either a master's degree or doctorate degree in counseling, and who specialized in play therapy. Two of the therapists were doctoral students who held master's degrees in counseling, and eleven were master's students who were in the final phase of their training. The CBCL, the PSI, and the JPPSST were administered for the purpose of pretest and posttest data collection. Pretest and posttest instruments were administered to experimental subjects by the play therapists who were administering the treatment. The instruments were administered immediately prior to treatment and immediately following treatment for the purpose of data collection. Control group subjects were administered the pretest and posttest instruments immediately prior to and immediately following a ten-week period whereby no treatment was administered.

All information provided by the participants was kept confidential. Names of both children and guardians were not disclosed in any publication or discussion of this material. Information obtained from assessments and questionnaires were recorded with a code number. Only the

investigator had a list of the participants' names and respective codes.

Statistical Analyses

Instruments were scored and double-checked following the collection of the pretests and posttests. The data were keyed into the computer and analyzed by the researcher using SPSS for MS Windows Release 8.0. The data were then analyzed via a sequence of two one-way multivariate analyses of variance (MANOVA). The independent variable for the analysis was group membership (i.e. experimental and control); the dependent variables for the first MANOVA consisted of change scores on the Total CBCL, Total PSI, and the JPPSST. The dependent variables for the second MANOVA consisted of change scores for the Internalizing and Externalizing subscales of the CBCL and the Parent Domain, Child Domain, and Life Stress subscales of the PSI. A MANOVA of change scores was deemed more appropriate than analyzing the data using a MANCOVA. Specifically, a MANOVA was utilized to analyze change from pretest to posttest as opposed to artificially equating the groups at pretest as in MANCOVA (Maxwell & Delaney, 1990). A level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data for each hypothesis tested in this study. Included also is a discussion of the results, implications, and recommendations.

Results

The results of this study are presented in the order the hypotheses were tested. Multivariate analyses were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses. Results of evaluation of assumptions of normality, homogeneity of variance-covariance matrices, linearity, multi-collinearity, and detection of outliers were deemed satisfactory.

The data were analyzed via a sequence of two one-way multivariate analyses of variance (MANOVA). The independent variable for the analysis was group membership (i.e. experimental or control). The dependent variables for the first MANOVA consisted of change scores on the JPPSST,

Total CBCL, and Total PSI. The dependent variables for the second MANOVA consisted of change scores for the internalizing and externalizing subscales of the CBCL, and the Parent Domain and the Child Domain of the PSI. Table 2 presents the results of the first MANOVA. Table 2 presents the results of the second MANOVA.

Table 2.

Multivariate Analysis of Variance for the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST), the Total Behavior Problems scale of the Child Behavior Checklist (CBCL), and the Total Stress scale of the Parenting Stress Index (PSI)

F-Tests	F Ratio	df	p	η^2
Multivariate Analysis				
Wilks Lambda	1.20	3,22	.33	.14
Univariate Analysis				
CBCL	.68	1,24	.42	.03
PSI	3.57	1,24	.07	.13
JPPSST	.11	1,24	.74	.01

The first MANOVA using the Total Scores from the CBCL, PSI, and JPPSSC was not significant, $F(3.22) = 1.204$, $p = .33$, $\eta^2 = .14$ (see Table 2). Although the MANOVA was not

significant, the effect size was sufficiently large enough to present the univariate ANOVAs for clarification. It is presumed that the lack of significance was due to low power due to small group sizes as opposed to the absence of a group effect.

Analysis of the univariate ANOVAs (i.e. change scores for JPPSSC, Total CBCL, and Total PSI) revealed that the change in parenting stress demonstrated a marginally significant difference between experimental and control groups, $F(1,24) = 4.566$, $p = .07$, $\eta^2 = .13$ (see Table 2). As seen in Table 10, analysis of the mean change scores demonstrated that subjects in the experimental group (mean = 36.38; standard deviation = 50.88) demonstrated a larger decrease in stress than did subjects in the control group (mean = 5.38; standard deviation = 30.26).

The second MANOVA using scores from the CBCL subtests, Internalizing Behavior scale and Externalizing Behavior scale; and from PSI subtests, Child Domain and Parent Domain, was significant $F(5,21) = 6.69$, $p = .001$, $\eta^2 = .61$ (see Table 11). Therefore, it was necessary to proceed to interpreting the univariate ANOVAs (see Table 3). Analysis of the univariate ANOVAs revealed that the change in

Internalizing Behaviors demonstrated a significant difference between experimental and control groups, $F(1,25) = 4.085$, $p = .05$, $\eta^2 = .14$ (see Table 3).

Table 3.

Multivariate Analysis of Variance for Externalizing Behaviors of the CBCL, Internalizing Behaviors of the CBCL, Parent Domain of the PSI, Child Domain of the PSI

F-Tests	F Ratio	df	p	η^2
Multivariate Analysis				
Wilks Lambda	6.69	5,21	.001	.61
Univariate Analysis				
Externalizing (CBCL)	.083	1,25	.78	.00
Internalizing (CBCL)	4.085	1,25	.05	.14
Parent Domain (PSI)	.276	1,25	.60	.01
Child Domain (PSI)	.885	1,25	.36	.03
Life Stress (PSI)	2.192	1,25	.15	.08

Analysis of the mean change scores revealed that subjects in the experimental group (mean = 8.07; standard deviation = 9.18) demonstrated a significantly larger decrease in internalizing behaviors than did subjects in the control group (mean = 1.85; standard deviation 6.48).

None of the other subtests demonstrated significant differences between the two groups (see Table 3).

Hypothesis 1

Children in the experimental group will attain a significantly higher mean total score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) at posttesting than will children in the control group.

Table 4 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 5 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 6 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 4.

Mean Scores and Standard Deviations on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	27.231	2.488	27.231	3.398
Control	13	24.539	5.332	25.231	4.729

Table 5.

Mean of Gain Scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Group	n	Gain Mean	SD
Experimental	13	0.000	3.916
Control	13	.692	6.290

Table 6.

Analysis of Variance Data for Mean Scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	3.115	1	3.115	.113	.74	.01
Error	658.769	24	27.449			

Table 6 shows the F ratio for the group was not significant to the $<.05$ level indicating there was not a significant increase in the experimental group's self-concept as measured by the JPPSST. On the basis of these data, hypothesis 1 was rejected.

Hypothesis 2

Children in the experimental group will attain a significantly lower mean total score on Total Behavior Problems on the Child Behavior Checklist (CBCL) posttest than will children in the control group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 8 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 9 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 7.

Mean Scores and Standard Deviations on the Total Behavior Problems Scale of the Child Behavior Checklist (CBCL)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	62.321	8.095	56.154	10.792
Control	13	56.615	9.456	48.769	9.671

Table 8.

Mean of Gain Scores on the Total Behavior Problems Scale of the Child Behavior Checklist (CBCL)

Group	n	Gain Mean	SD
Experimental	13	6.079	7.911
Control	13	3.846	5.684

Table 9.

Analysis of Variance Data for Mean Scores on the Total Behavior Problems Scale on Child Behavior Checklist (CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	32.346	1	32.346	.682	.42	.03
Error	1138.615	24	47.442			

Table 9 shows the F ratio for the group was not significant to the $<.05$ indicating there was not a significant decrease in the experimental group's behavior problems as measured by the CBCL. On the basis of these data, hypothesis 2 was rejected.

Hypothesis 3

Parents of children in the experimental group will

attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will parents of children in the control group.

Table 10 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 11 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 12 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 10.

Mean Scores on the Total Stress Scale of the Parenting Stress Index (PSI)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	274.000	61.111	237.615	21.204
Control	13	204.923	41.574	199.539	37.148

Table 11.

Mean of Gain Scores on the Total Stress Scale of the Parenting Stress Index (PSI)

Group	n	Gain Mean	SD
Experimental	13	36.385	50.887
Control	13	5.385	30.256

Table 12.

Analysis of Variance Data for Mean Scores on the Total Parenting Stress Index (PSI)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	6246.500	1	6246.500	3.566	.07	.13
Error	42046.154	24	1751.923			

Table 12 shows the F ratio for the group was not significant to the <.05 level indicating there was not a significant decrease in the experimental group parents' overall levels of parenting stress as measured by the PSI. On the basis of these data, hypothesis 3 was rejected.

Hypothesis 4

Children in the experimental group will attain a significantly lower mean score on Externalizing Behavior Problems of the CBCL posttest than will children in the control group.

Table 13 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 14 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 15 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 13.

Mean Scores on the Externalizing Behavior Problems Subscale on the Child Behavior Checklist (CBCL)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	61.846	10.463	59.615	12.149
Control	13	51.077	11.565	49.154	10.049

Table 14.

Mean of Gain Scores on the Externalizing Behavior Problems
Subscale of the Child Behavior Checklist (CBCL)

Group	n	Gain Mean	SD
Experimental	13	2.643	7.302
Control	13	1.923	5.454

Table 15.

Analysis of Variance Data for Mean Scores on the
Externalizing Behavior Problems Subscale of the Child
Behavior Checklist (CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	3.492	1	3.492	.083	.78	.003
Error	1050.137	25	42.005			

Table 15 shows the F ratio for the group was not significant to the <.05 level indicating there was not a significant decrease in the experimental group's behavior problems as measured by the CBCL. On the basis of these data, hypothesis 4 was rejected.

Hypothesis 5

Children in the experimental group will attain a significantly lower mean score on Internalizing Behavior Problems on the CBCL posttest than will children in the control group.

Table 16 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 17 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 18 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 16.

Mean Scores on the Internalizing Behavior Problems Subscale of the Child Behavior Checklist (CBCL)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	58.308	10.169	51.077	9.178
Control	13	49.769	8.955	47.923	9.691

Table 17.

Mean of Gain Scores on the Internalizing Behavior Problems
Subscale of the Child Behavior Checklist (CBCL)

Group	n	Gain Mean	SD
Experimental	13	8.071	9.177
Control	13	1.846	6.479

Table 18.

Analysis of Variance Data for Mean Scores on the
Internalizing Behavior Problems Subscale of the Child
Behavior Checklist (CBCL)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	261.231	1	261.231	4.085	.05	.14
Error	1598.621	25	63.945			

Table 18 shows the F ratio for the group was significant to the <.05 level indicating there was a significant decrease in the experimental group's internalizing behaviors as measured by the CBCL. On the basis of these data, hypothesis 5 was retained.

Hypothesis 6

Parents of children in the experimental group will attain a significantly lower mean total score on the Parent Domain of the PSI posttest than will children in the control group.

Table 19 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 20 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 21 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 19.

Mean Scores on the Parent Domain of the Parenting Stress Index (PSI)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	274.000	61.111	237.615	21.204
Control	13	204.942	41.574	199.539	37.148

Table 20.

Mean of Gain Scores on the Parent Domain of the Parenting Stress Index (PSI)

Group	n	Gain Mean	SD
Experimental	13	27.071	23.463
Control	13	22.462	22.033

Table 21.

Analysis of Variance Data for the Mean Scores on the Parent Domain of the PSI

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	143.248	1	143.248	.276	.60	.01
Error	12982.159	25	519.286			

Table 21 shows the F ratio for the group was not significant to the <.05 level indicating there was not a significant decrease in the experimental group parents' stress levels in the Parent Domain as measured by the PSI. On the basis of these data, hypothesis 6 was rejected.

Hypothesis 7

Parents of children in the experimental group will attain a significantly lower mean total score on the Child Domain of the PSI posttest than will parents of children in the control group.

Table 22 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 23 presents the analysis of variance mean gain scores, showing the difference between the experimental and control groups. Table 24 presents the analysis of variance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 22.

Mean Scores on the Child Domain of the Parenting Stress Index (PSI)

Group	n	<u>Pretest</u>		<u>Posttest</u>	
		Mean	SD	Mean	SD
Experimental	13	121.692	19.551	112.692	17.056
Control	13	93.692	18.657	88.769	15.128

Table 23.

Mean of Gain Scores on the Child Domain of the Parenting Stress Index (PSI)

Group	n	Gain Mean	SD
Experimental	13	9.643	10.434
Control	13	4.923	15.354

Table 24.

Analysis of Variance Data for Mean Scores on the Child Domain of the Parenting Stress Index (PSI)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	p	η^2
Group	150.139	1	150.159	.885	.36	.03
Error	4244.137	25	169.765			

Table 24 shows the F ratio for the group was not significant to the <.05 level indicating there was not a significant decrease in the experimental group parents' stress levels in the Child Domain as measured by the PSI. On the basis of these data, hypothesis 7 was rejected.

Discussion

The results of this study revealed that children receiving individual play therapy experience at least moderate improvement in adjustment difficulties. Of the 7 presented hypotheses, 1 was retained and the other 6 were rejected. However, a positive trend is evidenced in each of the dimensions under investigation, with the exception of self-concept, which remained stable. An explanation of these findings is discussed below.

Self-Concept

Experimental group children showed no significant improvement in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) (gain mean = 0.000). However, parents' comments and therapists' observations supported the notion that most of these children demonstrated greater self-confidence, increased autonomy, and improved comfort in social situations and interpersonal relationships - all characteristic of an improved self-concept (Joseph, 1979).

For example, one father of an experimental group child reported that his son had become more "self-assured" since he started receiving play therapy. The father stated, "Chris is initiating more frequent interactions with peers;

and at school, he is starting to raise his hand to answer questions - something he has not attempted in the past for fear of what the other children would think of him if his answer were wrong." Several play therapists also elaborated on how experimental group children developed more confidence and independence. One therapist described a child's improved self-esteem and resulting behaviors over the course of treatment:

Sara was referred for play therapy by her mother due to feelings of inadequacy and dependency, low tolerance for frustration, and poor self-control. She displayed her feelings of inadequacy and dependence by constantly asking me to help her accomplish simple tasks, such as removing the lid from a marker. Sara displayed low frustration tolerance by either asking me for help after only one attempt to accomplish a task or abruptly moving to something else if she did not see immediate results. She demonstrated poor self-control by continuously breaking playroom rules and requiring me to repeatedly set limits.

By the 10th session, Sara was completing tasks by herself and attempting difficult tasks several times before asking for help. Additionally, I did not have

to set as many limits and the limits that were set usually called for me to set them only once. Sara also began to play more independently throughout the play therapy sessions. In the beginning, she seemed uncomfortable playing by herself and frequently involved me in her play. By the final session, she was much more content playing on her own, while occasionally engaging me in some of her activities.

The discrepancy between parent and therapist observations and the statistical findings has several possible explanations. Important is the possible existence of a ceiling effect, one of the limitations of performing a gain scores analysis (Gall, Borg, & Gall, 1996) due to children rating themselves in the moderately high to high range at the administration of the pretest. A ceiling effect would place a restriction on the distribution of gain scores across initial levels of self-concept, leaving virtually no room for improvement. Although there appears to have been observable improvement as reported by parents and play therapists, children in the experimental group did not report significant change as a group (gain mean = 0.000) in perception of self.

There are several possible explanations for the

occurrence of a ceiling effect in this study. First, all of the participants' behavioral problems developed after the occurrence of one or more recent life changes, such as starting kindergarten, divorce of parents, moving, death in the family, birth of a sibling, etc.; and it is believed that participants' internalizing and externalizing behaviors are manifestations of their attempts to adjust to recent experiences in their lives (Gil, 1991). Since self-concept is a part of the individual that is stable over time (Joseph, 1979; Brownfain, 1965; Rogers, 1951), there may not have been enough time between the precipitating life events and the administration of the pretest for children to experience a change in self view. Thus, their reports revealed high self-concepts. If this is the case, it is hoped that play therapy has made a large enough impact on the experimental group children to prevent any future damage to their self-concepts by ameliorating current behaviors that may have otherwise resulted in negative emotional consequences.

A second possible reason for a ceiling effect is that children with serious adjustment difficulties may have distorted self-perceptions. One analysis of construct validity for the JPPSST showed interesting results (Joseph,

1979). In 11% of the participating children extreme divergence was noted, meaning that some of the children obtained a high subjective self-rating paired with a low-external rating (as rated by teachers), while others gave themselves a low self-rating despite receiving high external ratings. Another analysis of construct validity for the JPPSST suggested that severely emotionally disturbed children had serious pathological self-concept development. Thus, in cases where children are experiencing more severe emotional and behavioral problems, their self-perceptions may have a tendency to be less accurate than in cases which are not as severe.

Finally, discussions with therapists after the pretest administration revealed that, overall, the therapists believed the instrument was not a reliable predictor of the children's self-concepts. The therapists reported that some of the children seemed to be concerned about choosing the "right" or "most desirable" response to each of the test questions. Also, the therapists expressed concern that the instrument was not valid with inattentive/impulsive children who tended to "blurt out" responses to questions while, at the same time, it appeared that they were not attending well enough to hear the questions at hand.

In summation, improvements in self-concept may not be detected at posttest administration since the children already scored relatively high as a group on the pretest (which may be due, in part, to self-concepts that had been unaffected by recent life changes at the time of pretesting; to inaccurate self-perceptions; and/or a tendency to choose the most desirable responses) leaving no room for significant improvement.

Behavioral Problems

Experimental group children demonstrated fewer behavior problems than did control group children (experimental mean gain = 6.079; control mean gain = 3.846) at the time of the posttest as measured by the Child Behavior Checklist (CBCL), which encompasses ratings by parents. Although change in the Total Score of the Child Behavior Checklist did not reveal significant findings, significant change was found in the Internalizing Behavior Problems scale (significance: $p = .05$). This subscale includes scores on the following emotional and behavioral factors: withdrawn, somatic complaints, and anxious/depressed. Children who exhibit such behaviors tend to negotiate difficult experiences in their lives by themselves; they do not interact with others (Gil, 1991)

Having a significantly lower mean for Internalizing Behavior Problems at posttest indicates a reduction of internalizing behavior problems as perceived by parents. This reduction is particularly noteworthy since internalizing behavior problems are more difficult to detect and are oftentimes overlooked by parents.

Children who exhibit externalizing behaviors express their emotions outwardly and, therefore, direct behaviors outward toward others (Gil, 1991). Although findings were not statistically significant on the Externalizing Behavior Problems subscale, slight improvement was detected in the experimental group children's scores (see Tables 13, 14, 15). Additionally, parents and play therapists, alike, noted decreases in externalizing behavior problems in some of the experimental group children. For example, one mother commented that she started witnessing "fewer temper tantrums and out of control behavior" in her five-year-old daughter beginning at approximately the fifth week of play therapy intervention.

The play therapists also noted improvement in some of the externalizing behavior problems. One therapist observed noticeable changes in both internalizing and externalizing behaviors in a child from the experimental group:

Amy was referred for play therapy by her aunt (her custodial caregiver) for adjustment problems due to several recent life changes. Specifically, Amy was suffering from severe anxiety, engaging in out-of-control behavior and self-abuse, soiling her pants, frequently wetting her bed, and dealing with delayed speech. She had a history of suspected physical abuse and neglect by her biological parents. After 10-weeks of play therapy, Amy's aunt reported that she no longer soiled her pants, her bedwetting had become infrequent, she was no longer hurting herself, and she had more self-control. Additionally, her speech had also become clearer as she demonstrated improved vocabulary and improved articulation of her actions. Another therapist reported improvement on externalizing behavior problems in a child in the experimental group. The child was referred by his parents for play therapy due to social withdrawal and anger outbursts at home and at school. Additionally, the parents reported having marital problems at the time of referral. The therapist described the child's progress as follows:

During our first few play therapy sessions, Sam was very quiet and reserved, never including me in his

play. Also, Sam expressed a great deal of anger and had low frustration tolerance, as demonstrated by his play behaviors. He outwardly tested limits and expressed anger towards me. By the end of the 10-week period, I noticed several changes and improvements in Sam's behavior. First, he showed self-control, no longer testing all limits of the playroom and he began demonstrating self-responsibility by creating his own limits. Also, his expression of anger decreased and appeared to become replaced by self-nurturing behaviors. Finally, Sam began to make noticeable efforts to initiate contact with me, showing me things and engaging me in mutual activities with him.

Although I would recommend Sam for continued involvement in play therapy, his level of improvement over the 10-week period is still worth noting.

One possible explanation for the discrepancy between statistical results on the Externalizing Behavior Problems subscale of the CBCL and parent and therapist observations may be children's inability to show significant gains in only 7 to 10 weeks. Humanistic-based play therapy does not have individualized prescriptive goals for changing specific problematic behavior. Rather, it focuses on the

person of the child with emphasis on "facilitating the child's efforts to become more adequate, as a person, in coping with current and future problems which may impact the child's life" (Landreth, 1991, p. 80). Humanistic forms of play therapy are aimed at helping the child tap into his or her own internal resources for solving problems and effectively resolving issues in life. All changes that are taking place within the child may not immediately manifest themselves in observable behaviors. However, in the long-run, it is possible that such changes may become significant.

Despite some discrepancies between parent and therapist and statistical findings, improvement was demonstrated on all dimensions of the CBCL, with significant improvement on the experimental group's internalizing behavior problems.

Parenting Stress

The results of the analysis of parenting stress approached statistical significance at $p = .07$ (experimental gain mean = 36.385; control gain mean = 5.385), meaning parents of experimental group children perceived their role as parents to be considerably less stressful than did control group parents after the

treatment period. Overall, parents of children in the experimental group reported decreased levels of stress in both the Parent Domain and the Child Domain. High scores in the Parent Domain suggest that "sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning" (Abidin, 1983, p. 61). A slight reduction in parenting stress was noted in the Parent Domain for parents' of children in the experimental group (experimental gain mean = 27.071 and control gain mean = 22.462). High scores in the Child Domain suggest that certain characteristics of the child may be contributing to the level of stress in the parent-child relationship (Abidin, 1983). Levels of parenting stress in the Child Domain were also reduced in parents of children in the experimental group after those children had received play therapy (experimental gain mean = 9.643 and control gain mean = 4.923).

A likely explanation for the reduction in parenting stress is that play therapy helped reduce undesirable behaviors in the experimental group children (as indicated by improvements on the CBCL) and consequently, reduced the amount of strain in the parent-child relationship. It is worth mentioning, however, that if parents had received

parenting training concurrently with their children receiving play therapy, a significant decrease in parenting stress may have likely occurred. One parent of a child in the experimental group shared her assessment of play therapy's contribution to her child's social and emotional adjustment, as witnessed at home and in school. She believed the observed changes in behaviors alone helped her to more easily accept her child:

Paul is less disobedient and much less manipulative since we started him in play therapy. So, I think I am beginning to notice some of his 'better traits'; and the overall level of stress in our home has noticeably decreased.

An important observation is the fact that posttests were administered during the month of December. Several parents gave verbal reports to therapists about feeling very stressed around the Holidays with the demands of holiday shopping, preparation for out-of-town guests, and demands of their children's schools with the semester coming to an end. Despite such reports of having "additional" stressors, results of the analysis still showed a considerable decline in the level of parenting stress in parents of experimental group children after

their children received play therapy.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. Conducting a similar study utilizing a larger sample size ($n \geq 50$) in order to increase the power of the investigation.
2. Conducting a follow-up study to investigate the long-term effects of individual play therapy in treating a variety of adjustment difficulties in young children.
3. Designing and implementing a comparative study aimed specifically at investigating the effects of play therapy on internalizing vs. externalizing behavior problems.
4. Drawing subjects from the same population and randomly assigning them to experimental and control groups in order to meet the requirements of a true experimental design.
5. Providing a longer duration of treatment (≥ 20 weeks).
6. Selecting more experienced play therapists to

providing treatment to the experimental group.

7. Directly involve parents in the intervention process.

Concluding Remarks

This study has demonstrated the effectiveness of play therapy as a viable intervention for a variety of emotional and behavioral problems in children; particularly, difficulties such as shyness, social withdrawal, somatic complaints, anxiety and depression. Children receiving play therapy demonstrated more improvement in adjustment problems, and parents evidenced less parenting stress, than children who were not receiving any type of intervention. The most remarkable improvements were observed in internalizing behaviors. Specifically, children became more socially interactive, experienced less anxiety, evidenced less somatic complaints, withdrew from social situations less often, and demonstrated greater feelings of security and contentment with themselves.

Play therapy can serve as a treatment for problematic behaviors and has the potential to preclude the development of future emotional and behavioral problems. In addition to ameliorating immediate adjustment difficulties, play therapy can foster improved social acceptance by peers,

family, teachers, and others. Social acceptance and a sense of belonging help provide security, comfort, and confidence in one's surroundings; and help foster the development of a positive self-concept. Joseph (1979) believed a child's self-concept may be the best predictor of a child's ability to succeed in life due to its instrumental role in influencing "emotional growth, academic achievement, interpersonal relationships, and the outcome of major life experiences" (p. 1). Social acceptability, a sense of belonging, and a healthy self-concept will benefit all children throughout the duration of their development and will help to ensure their becoming fully-functioning, socially-minded, well-adjusted adults.

APPENDIX A
INFORMATION FOR PARENTS

PLAY THERAPY RESEARCH

Information for Parents

You and your child are invited to participate in a study to determine the effectiveness of play therapy. Participation is completely voluntary. If you choose to participate, you will be asked to complete two questionnaires before and after a 7-10-week period. In addition, your child will be administered a 10 minute, 20 question, self-concept inventory before and after the 6-10-week period.

Play therapy is a special approach to helping children with their problems through the use of selected play materials. A trained play therapist helps children to express feelings, thoughts, experiences, and behaviors through the child's natural medium of communication, play. The possible benefits of play therapy are: (a) improvement in the child's self-esteem, (b) amelioration of behavioral and emotional difficulties, (c) improved relationship between parent and child, and (d) improvement in the child's school performance.

The information provided by you in the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from assessments and questionnaires will be recorded with a code number. Only the investigator, Marielle A. Brandt, will have a list of the participants' names. At the conclusion of this study, the list of participants' names will be destroyed.

Participants will be assigned to either a treatment group or a control group. Control group children will be selected from an elementary school in the Denton County Independent School District, while experimental children will be selected from both the Child and Family Resource Clinic (CFRC) and the Counseling and Human Development Center (CHDC). This study involves no personal risk or discomfort to participants.

All procedures and testing that will take place in the investigation are "standard procedures" of both CFRC and the CHDC. The instruments to be employed in this study are the same instruments used for any child receiving play therapy at CFRC or CHDC. All therapists are graduate students at the University of North Texas, specially trained in play therapy. The play therapists will employ the same methods and techniques with the subjects under study as with any other child under their care at CFRC or the CHDC. The only unique circumstance is that data collected from participants will be utilized for the purpose of this study.

You and/or your child may choose to withdraw at any time without penalty or prejudice. At the conclusion of the study, a summary of group results will be made available to all interested parents and teachers.

If you agree to participate, please fill out and sign the attached consent form. For further information, please contact Marielle A. Brandt, researcher, at (940) 484-1241, or Dr. Sue C. Bratton, Faculty Supervisor, at (940) 565-2066.

APPENDIX B
PARENT INFORMED CONSENT

PLAY THERAPY RESEARCH

Parent Informed Consent

You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented on this form and until all your questions about the research have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may choose to withdraw at any time during the study. Your signature indicates that you meet all the requirements for participation as explained by Marielle A. Brandt and have decided to participate, having read the information on this form.

Signature of Parent or Legal Guardian

Date

Name of Child

Age

Signature of Witness

Date

Signature of Investigator

Date

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the protection of human subjects (940) 565-3940.

APPENDIX C
CHILD INFORMED CONSENT

PLAY THERAPY RESEARCH

Child Informed Consent

I understand that I am going to be part of a project with a play therapist who my parents or guardians will take me to visit every week. For ten weeks, I will meet with this play therapist in a special play room for 45 minutes once each week. I understand that I can stop taking part in this project at any time I choose.

My “mark”, or signature, means that I understand what has been explained to me and that I am willing to be part of this project.

Signature of Child

Date

Name of Child

Age

Signature of Parent

Date

Signature of Investigator

Date

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the Protection of Human Subjects (940) 565-3940.

REFERENCES

- Abidin, R. (1983). Parenting stress index. Charlottesville, VA: Pediatric Psychology Press.
- Achenbach, T. M. (1991). Manual for child behavior checklist and 1991 profile. Burlington, VT: University Associates in Psychiatry.
- Achenbach, T. & Edelbrock, C. (1983). Child behavior checklist. Burlington, VT: Author.
- Allen, F. H. (1942). Psychotherapy with children. New York: Norton.
- Axline, V. M. (1947). Play therapy: The inner dynamics of childhood. Boston: Houghton Mifflin.
- Bills, R. E. (1950). Non-directive play therapy with retarded readers. Journal of Consulting Psychology, 14, 140-149.
- Brownfain, J. (1965). Stability of the self-concept as a dimension of personality. In D. E. Hamacheck (Ed.), The self in growth, teaching, and learning. Englewood Cliffs, N. J.: Prentice-Hall.
- Clatworthy, S. (1981). Therapeutic play: effects on hospitalized children. Journal of Association for Care of

Children's Health, 9(4), 108-113.

Crow, J. (1990). Play therapy with low achievers in reading. Doctoral dissertation, University of North Texas, 1989. Dissertation Abstracts International, 50(9), B2789.

Crowley, S. L. (1985). Family functioning in families of children with disabilities: An intensive psychometric investigation of five family measures. Doctoral Dissertation, Utah State University.

Daniel, C. A., Rae, W. A., Sanner, J. H., Upchurch, J., & Worchel, F. R. (1989). The psychosocial impact of play on hospitalized children. Journal of Pediatric Psychology, 14(4), 617-627.

Donovan, D. M. (1997). Therapeutic play. Journal of the American Academy of Child and Adolescent Psychiatry, 36(1), 3-5.

Erikson, E. H. (1964). The meaning of play. In M. Haworth (Ed.), Child psychotherapy, (pp. 3-11). New York: Basic Books.

Erikson, E. H. (1940). Studies in the interpretation of play. Genetic Psychology Monograph, 22, 557-571.

Frank, L. K. (1955). Therapeutic play techniques: Play in personality development. American Journal of Orthopsychiatry, 25, 576-590.

Friedman, S. (1997). Time-effective psychotherapy: Maximizing outcomes in an era of minimized resources. Boston: Allyn & Bacon.

Freud, A. (1946). The psycho-analytical treatment of children. New York: International Universities.

Gadow, K. D., & Pomeroy, J. C. (1993). Pediatric psychopharmacotherapy: a clinical perspective. In T. Kratochwill & R. Morris (Eds.), Handbook of psychotherapy with children and adolescents, pp. 356-402. Boston: Allyn & Bacon.

Gelfand, D. M.; Jensen, W. R.; Drew, C. J. (1997). Understanding child behavior disorders (3rd ed.). Orlando: Harcourt Brace.

Gil, E. (1991). The healing power of play: working with abused children. New York: Guilford Press.

Ginott, H. (1960). A rationale for selecting toys in play therapy. Journal of Consulting Psychology 24(3), 243-246.

Ginsberg, L. (1995). Social work almanac (2nd ed.). Washington, D. C.: NASW Press.

Gullotta, G., Adams, G. R. & Montemayor, R. (1998). Delinquent violent youth: theory and interventions. Thousand Oaks, CA: Sage.

Hambidge, G. (1955). Structured play therapy. American Journal of Orthopsychiatry, 25, 601-617.

Hauenstein, E., Scarr, S., & Abidin, R. R. (1987). Detecting children at-risk for developmental delay: Efficacy of the Parenting Stress Index in a non-American Culture. Unpublished manuscript, University of Virginia at Charlottesville.

Kelley, M. (1985). Review of Child Behavior Checklist. In J. V. Mitchell (Ed.). The Ninth Mental Measurements Yearbook, Vol. I. Lincoln, NE: University of Nebraska Press.

Klein, M. (1955). The psychoanalytic play technique. American Journal of Orthopsychiatry, 25, 223-227.

Kot, S. (1995). Intensive play therapy with child witnesses of domestic violence. Unpublished dissertation, University of North Texas, Denton, TX.

Krall, V. (1989). A play therapy primer: Therapeutic approaches to children with emotional problems. New York: Human Sciences Press.

Landreth, G. L. (1996). Play therapy interventions with children's problems. Northvale, NJ: Aronson

Landreth, G. L. (1993). Self-expressive communication. In C. E. Schaefer (Ed.), The therapeutic powers of play

(pp. 41-63). Northvale, NJ: Aronson.

Landreth, G. L. (1991). Play therapy: The art of the relationship. Muncie, IN: Accelerated Development Press.

Landreth, G. L. (Ed.). (1982). Play therapy: Dynamics of the process of counseling with children. Springfield, Illinois: Thomas.

Landreth, G. L., Homeyer, L. E., Glover, G. & Sweeney, D. S. (1996). Play therapy interventions with children's problems. New Jersey: Aronson.

Levy, D. (1939). Trends in therapy: Release therapy. American Journal of Orthopsychiatry, 3, 266-277.

Lowenfield, M. (1935). Play in childhood. London: Gollancz.

McMahon, L. (1992). The handbook of play therapy. London: Routledge.

Milos, M. E., & Reiss, S. (1982). Effects of three play conditions on separation anxiety in young children. Journal of Counseling and Consulting Psychology, 50(3), 389-395.

Moustakas, C. E. (1959). Psychotherapy with children: The living relationship. New York: Harper.

Mundy, L. (1957). Therapy with physically and mentally handicapped children in a mental deficiency hospital.

Journal of Clinical Psychology, 3-9.

Newcomer, B. L., & Morison, T. L. (1974). Play therapy with institutionalized mentally retarded children. American Journal of Mental Deficiency, 78(6), 727-733.

O'Connor, K. (1991). The play therapy primer: An integration of theories and techniques. New York: John Wiley & Sons.

Oulline, V. J. (1975). Behavioral outcomes of short-term non-directive play therapy with preschool deaf children. Unpublished doctoral dissertation, North Texas State University, Denton, TX.

Patterson, C. (1974). Relationship counseling and psychotherapy. New York: Harper & Row.

Pelham, L. E. (1972). Self-directive play therapy with socially immature kindergarten students. Doctoral dissertation, University of Northern Colorado, 1971. Dissertation Abstracts International 32(07): A378.

Perez, C. (1987). A comparison of group play therapy and individual play therapy for sexually abused children. Doctoral dissertation, University of Northern Colorado. Dissertation Abstracts International, 48, (12A).

Piaget, J. (1962). Play, dreams and imitation in childhood. New York: Norton.

Piaget, J. (1952). The origins of intelligence in children. New York: Norton.

Piaget, J. (1980). Schemes of action and language learning. In Piattelli-Palmarini, M. (Ed.), Language and learning: the debate between Jean Piaget and Noam Chomsky. Cambridge: Harvard University Press.

Pines, M. (1983). In D. E. Papalia, & S. W. Olds, Human development, (5th ed.). New York: McGraw-Hill.

Quayle, R. L. (1991). The primary mental health project as a school-based approach for prevention of adjustment problems: an evaluation. Unpublished dissertation.

Rank, O. (1936). Will therapy. New York: Knopf.

Rogers, C. (1951). Client-centered therapy: It's current practice, implications, and theory. Boston: Houghton, Mifflin.

Satir, V. (1983). Conjoint family therapy (3rd ed.). Palo Alto, CA: Science & Behavior Books.

Satir, V.; Banmen, J.; Gerber, J.; & Gomori, M. (1991). The Satir model: Family therapy and beyond. Palo Alto, CA: Science & Behavior Books.

Schaefer, C. E. (1993). The therapeutic powers of play. Northvale, NJ: Aronson.

Schaefer, C. E. (1985). Play therapy. Early Child Development and Care, 19(2), 95-108.

Schaefer, C. E. & O'Connor, K. (Eds.) (1983). Handbook of play therapy. New York: Wiley & Sons.

Siegel, C. L. F. (1970). The effectiveness of play therapy with other modalities in the treatment of children with learning disabilities. Dissertation Abstracts International 31(08):A3970.

Sinclair-deZwart, H. (1973). Language acquisition and cognitive development. In Moore, T. E. (Ed.), Cognitive development and the acquisition of language. New York: Academic Press.

Yawkey, T. D. & Pelligrini, A. D. (1984). Child's play and play therapy. Lancaster, PA: Technomic Publishing.

Zakreski, J. (1983). Prematurity and the single parent: Effects of cumulative stress on child development. Unpublished doctoral dissertation: University of Virginia, Institute of Clinical Psychology.